State of Missouri
Department of Insurance
Managed Care Section

This checklist is a minimum representation of the items the Department considers when reviewing HMO evidences of coverage. This list is in no way an exhaustive or complete statement of all requirements and provisions that might be applicable to any specific provider agreement. **Please refer to the statues and regulations for exact wording of requirements or prohibitions. The language within the Missouri Statues and Regulations always prevails over this checklist.**

Company Name: _____

Form # as it appears on the TD-1: _____

Assigned MDI File # _____

HMO Evidences of Coverage

This form will be used in the following markets (please indicate all that apply):

Large Group	Small Group	Individual

Citation	Summary	Location in Contract (page and section #) If Applicable
The following items must appear in all provider contracts:		
20 CSR 400-8.200(3)(C)	Cover letter for filings must state if the form is intended to replace an existing form, or is a new form to be used in addition to existing forms.	
(3)(G)	Each form must have a form number assigned by the submitting HMO in the lower left corner of the face page or first page.	
(6)(A)	All forms must be accompanied by a completed TD-1.	
20 CSR 400-7.030	20 CSR 400-7.030 (all policy forms)	
(1)	Name, address, telephone number on face page	
(2)	Description of services, Copayment, other charges	
(3)	Cancellation notices, 31 day prior notice, group only: not prior to 1st anniversary	
(4)	Claim filing procedures	
(6)	Effective date requirements	
(7)	Eligibility requirements, dependents, limiting age	
(9)	Description of out of area benefits.	
(10)	Entire contract provision- any change must be approved an officer of the HMO	
(11)	Exclusions and limitations	
(12)	2 year incontestability	

(13)	Prior notification of rate changes	
(14)	Service area description	
(15)	Termination due to limiting age, effects of Medicare eligibility	
(15)(B)	Coverage for Handicap child past limiting age	
(16)	Where to obtain services	
(17)	Notice required if choice of providers is restricted	
20 CSR 400-7.040	20 CSR 400-7.040 (Group policy forms)	
(2)	Evidence of coverage delivered to each enrollee. Conflict between the EOC and the contract for coverage to be resolved in favor of the enrollee.	
(3)	How to add new employees	
(4)	Grace period (31 days)	
20 CSR 400-7.050	20 CSR 400-7.050 (Individual policy forms)	
(2)	Reinstatement requirements	
(3)	10 day right to examine agreement	
(4)	Original premium must be stated	
(5)	10-day grace period	
20 CSR 400-7.060	COB same as Group COB (20 CSR 400-2.030)	
20 CSR 400-7.100	Copayments (50% total cost of any single service, 20% aggregate cost of all basic health care, not to exceed 200% of total annual premium. Stated as dollar amount. Single service copays expressed as % or dollar amount in certificate.)	
20 CSR 400-7.150	Disenrollment - Not until collection efforts initiated (within 60 days after HMO notified copay is due). Enrollee notified (written notice) prior to disenrollment...given 10 working days to make arrangement.	
20 CSR 400-7.120	Enrollee participation	
354.400 RSMo.	Definitions (esp. new definition for emergency)	
354.442.1(14) RSMo.	listing by specialty of all participating providers updated at least annually	
354.462 RSMo.	Cancellation or non-renewal (only for failure to pay charges, fraudulent misuse of system, abusive conduct, failure to establish proper patient-physician relationship)	
354.546 RSMo.	Second opinions	
354.603.1(4) RSMo.	Clear statement that, not withstanding legitimate and medically based referral patterns, neither the HMO nor the participating providers shall act in a manner that unreasonably restricts an enrollee's access to the entire network, unless the HMO has a written agreement with the holder of the **benefits** contract to a reduced network, and has requested an exception	

	for a reduced network per 20 CSR 400-7.095 and filed an access plan for the reduced network prior to selling a new product, per 354.603.2.	
354.606.2 RSMo.	The enrollee may not be billed by the provider for anything other than copayments	
354.612 RSMo.	up to 90 day continuation of care when provider terminated, continued care at no greater cost	
354.615.1RSMo.	Referral to non-participating specialist, if none in network	
354.615.2 RSMo. .	Standing referral to specialist for ongoing care	
354.615.3 RSMo.	Referral to specialist for providing and coordinating services when life-threatening condition or degenerative disease or condition	
354.615.4 RSMo.	Same as 354.615.3 for specialty care centers	
354.618 RSMo.	Open referral/services of OB/GYN w/o PCP referral NOTE: This provision will be superseded by the applicable provisions of HB 762 as of 1-1-02. Refer to RSMo 376.1199.	
376.385 RSMo.	Diabetes equipment, supplies, etc - MANDATED OFFER	
376.395-404 RSMo.	Conversion upon termination of eligibility	
376.406 RSMo.	Coverage of newly born dependents, enrollment forms, additional 10 days to enroll a newly born dependent.	
376.428 RSMo.	Continuation for terminated members	
376.685-376.1220	Newborn Hearing Screening	
376.782 RSMo.	Mammography	
376.801 RSMo.	Child Health Supervision - OFFER (in writing)	
376.805 RSMo.	Elective abortions - only as Optional Rider	
376.810 RSMo.	Definitions: chemical dependency & mental illness	
376.811.2,3,4 RSMo.	Mental Illness benefits - OFFER	
376.816 RSMo.	Coverage for adopted children	
376.825-835 RSMo.	Mental Health & Chemical Dependency Minimums (If Coverage Included)	
376.891-894 RSMo.	Spousal continuation	
376.1199 RSMo.	Contraceptive coverage, bone density tests, open access to OB/GYNs	
376.1200 RSMo.	Chemotherapy/Bone Marrow Transplants - OFFER (in writing)	
376.1209 RSMo.	Coverage for mastectomies and reconstructive surgery, no time limit on reconstructive surgery	
376.1210 RSMo.	Minimum maternity benefits-48/96 hr inpatient, postdischarge, etc.	
376.1215 RSMo.	Childhood immunizations w/ no copay	
376.1219 RSMo.	PKU testing and formula	

376.1225 RSMo.	Coverage for hospital dental procedure	
376.1230 RSMo HB 121	Coverage for Chiropractic Care - shall provide chiropractic care, as defined in chapter 331, RSMo, as part of basic health care services for covered conditions. *Does not apply to individually underwritten policies*	
376.1250 RSMo.	Cancer Screenings (pelvic exam, prostate exam, colorectal exam, etc.)	
376.1350 RSMo.	Definitions UR	
376.1363 RSMo.	Notification requirements for UR determinations	
376.1367 RSMo.	UR or benefit determination for emergencies	
376.1372 RSMo.	UR procedures in EOC	
376.1378 RSMo.	Grievance procedures in EOC	
376.1382 RSMo.	Guidelines for grievance procedure identified	
376.1385 RSMo.	Guidelines for second level review	
376.1389 RSMo.	Procedure for expedited review	
	Provisions applicable to small group forms only:	
379.930.2(15) RSMo.	Eligible Employee	
379.930.2(19) RSMo.	Late enrollee, including all subsections	
379.930.2(25) RSMo.	Qualifying previous coverage defined	
379.930.2(28) RSMo.	Small employer defined	
379.938.4(2) RSMo.	Carrier's right to change premiums, and the factors besides claim experience that affect premiums	
379.940.2(1) RSMo.	S	
379.940.2(2) RSMo.	Credit for qualifying previous coverage and applicability of waiting period	
379.940.2(3) RSMo.	Waiting periods and/or pre-ex exclusions for late enrollees limited to 18 months	
	Nothing shall conflict with the following, although an evidence of coverage is not expressly required to state the following:	
376.383 - 376.384	rules for acknowledgement and prompt payment of claims, civil recourse available	
376.820 RSMo.	Child discrimination prohibited	
376.1361.10 RSMo.	Right to appeal for coverage of drugs & durable medical equip.	